Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

BOARD OF NURSING

APPLICATION FOR RE-REGISTRATION OF REGISTERED NURSE LICENSE

Information requested is required for processing.

PLEASE TYPE OR PRINT IN INK

Last Name: _____ **First Name:** _____ **MI:** _____

Former Name(s) - (If Applicable): _____

Street Address: _____
(A Post Office Box is NOT Acceptable)

City: _____ **State:** _____ **Zip:** _____

Phone (days): (____) _____ **Date of Birth:** _____

Ethnic and gender status information is optional, and is for research and reporting to the Equal Employment Opportunity Commission.

Race:
_____ (1) White, not of Hispanic origin
_____ (2) Black, not of Hispanic origin
_____ (3) Hispanic
_____ (4) American Indian or Alaskan
_____ (5) Asian or Pacific Islander
_____ (6) Other

Sex: _____ M _____ F

Primary Residence: _____ (State)
("state of primary residence" means the state of a person's declared fixed permanent and principal home for legal purposes, such as for voting, driver's license, or paying taxes).

Nursing School: _____

School Address: _____
(City) (State)

State of Original Licensure: _____

Date of Diploma: _____
month/day/year

Original Licensure Number: _____

Degree: _____

Date of Original Licensure: _____

APPLICATION FEES (Make check payable to Department of Regulation and Licensing and attach to application).

For Receipting Use Only

___ $ 66.00 Re-Registration Fee
$ 25.00 Late Renewal Fee
$ 91.00 Total fee attached

#2460 (Rev. 3/03)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

Fee(s) attached to this application (Form #772)

Addendum to Application Form (Form #2380)

Verification of Licensure (Form #741) or letters from all state boards where licensed (includes active and inactive licenses)

Copies of malpractice suit(s). Court documents with allegations and settlement (if applicable)

IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PRACTICE: Account for all activities and practice from date of graduation to the present time. **Must include professional and non-professional activities. ALL activities must be accounted for.**

	LOCATION	DATES (from - to) mo/yr
1.		
2.		
3.		
4.		

I AM LICENSED IN THE FOLLOWING STATES (UNLIMITED):

By Written Exam: _____

By Endorsement/Reciprocity: _____

YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN LICENSED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN BOARD OF NURSING. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, LICENSE NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE. (SUBMIT FORM #741 TO EACH STATE BOARD WHERE CREDENTIALED.)

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

		YES	NO
1.	Are you a nurse anesthetist CRNA?	☐	☐
2.	Do you anticipate taking the National Council Licensure examination (NCLEX) in another state? If yes, in which state and date: _____	☐	☐
3.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	☐	☐
4.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	☐	☐
5.	Have you ever failed to pass any state board examination, province of Canada examination, or NCLEX examination? If yes, give details on an attached sheet.	☐	☐
6.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	☐	☐
7.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	☐	☐

		YES	NO
8.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	❑	❑
9.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	❑	❑
10.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	❑	❑
11.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	❑	❑
12.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	❑	❑
13.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	❑	❑

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a registered nurse" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned nursing judgments and to learn and keep abreast of nursing developments; and
2. The ability to communicate those judgments and nursing information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform nursing tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

14.	Do you have a medical condition which in any way impairs or limits your ability to practice nursing with reasonable skill and safety? If yes, please explain.	❑	❑
15.	Does your use of chemical substance(s) in any way impair or limit your ability to practice nursing with reasonable skill and safety? If yes, please explain.	❑	❑

		YES	NO
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	❑	❑
17.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	❑	❑
18.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	❑	❑
19.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
20.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	❑	❑

AFFIDAVIT OF APPLICANT

I, the above-named applicant, state that I am the person referred to in this application and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my credential or other disciplinary action. I also understand that if I am issued a credential, failure to comply with the laws or rules of either the Board of Nursing or the Department of Regulation and Licensing will be cause for disciplinary action.

_____ _____

Applicant Signature Date

Subscribed and sworn to before me this _____ day of

_____ , 20 _____

_____ **SEAL**

Notary Public

_____

State

My Commission Expires: _____

NOTE: This affidavit must be signed by the applicant in the presence of the notary public on the same date.

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VERIFICATION OF LICENSURE

APPLICANT: Complete the top portion of this form and forward to the Board(s) in the state(s) in which you have ever been licensed. (This form may be copied.)

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____ ORIGINAL LICENSE # _____
(MONTH) (DAY) (YEAR) DATE ISSUED (YEAR)

NAME OF SCHOOL OF NURSING (NO INITIALS) _____

LOCATION _____
(CITY) (STATE) (COUNTRY)

I HEREBY AUTHORIZE THE _____ BOARD OF NURSING TO FURNISH THE WISCONSIN BOARD OF NURSING THE INFORMATION REQUESTED BELOW.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE

STATE BOARD: Please complete this section and submit it to the Wisconsin Board of Nursing at P.O. Box 8935, Madison, WI 53708.

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

Original License Number _____

Date of Issuance (Month/Day/Year) _____

Check one:
☐ RN
☐ LPN

Licensed By:
☐ Examination
☐ Endorsement
☐ Waiver

Was the examination in English?
☐ Yes ☐ No

Current Licensure Status:
☐ Active
☐ Inactive
☐ Lapsed

Has this license ever been encumbered (revoked, suspended, surrendered, restricted, limited, placed on probation, etc.) in any way?
☐ Yes ☐ No If yes, attach explanation and copy of the public documents.

SEAL

Signed: _____

Title: _____

State: _____ Date: _____

#741 (Rev. 9/02)
Ch. 441, Stats.

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ADDENDUM TO APPLICATION

Information requested is required for processing.

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____ ☐☐☐ - ☐☐ - ☐☐☐☐

First Name Middle Initial Last Name Social Security Number or FEIN

_____ Date of Birth _____

Type of Credential (license, permit, certificate)

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

INFORMATION AVAILABLE TO THE PUBLIC - NONDISCLOSURE OF CERTAIN PERSONAL INFORMATION

☐ Your name, credential number, address, status and other credentialing information are available to the public. However, you may check this box to declare that your name and address not be disclosed on any list of ten or more individuals that the department furnishes to another person.[5]

DELINQUENT STATE TAXES; DELINQUENT SUPPORT

All applications for professional credentials are checked to determine whether the applicant is liable for delinquent state taxes. Under state law, the department must deny your application if you are liable for delinquent Wisconsin taxes.[6] If you are liable for delinquent state taxes, pay the delinquent amount before the application process is completed. Retain proof that you have satisfied the tax delinquency. If you have any questions about payment of delinquent taxes, please contact your nearest Department of Revenue office or call (608) 261-6249. An application may be denied or a credential suspended if an applicant or credential holder is delinquent in paying support or fails to comply with a subpoena or warrant issued by the department of workforce development or a county child support agency related to support or paternity proceedings.[2]

#2380 (Rev. 11/02)

[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996
[5] Section 440.14, Wis. Stats.
[6] Section 440.12, Wis. Stats.

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

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CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a $6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth	Social Security Number
month _____ day _____ year _____	Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____

2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

   It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

OFFENSE	DATE	CITY/STATE

Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

		YES	NO	MO/YR COMPLETED
3.	Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program?	☐	☐	_____
	Did you successfully complete the program?	☐	☐	_____

Please attach the certificate of completion/discharge summary.

		(Check all that apply)	YES	NO	MO/YR COMPLETED
4.	Have you ever been sentenced to:	☐ Probation	☐	☐	_____
		☐ Parole	☐	☐	_____
		☐ Ordered to pay restitution	☐	☐	_____
	Did you successfully complete one of the above as ordered by the court?		☐	☐	_____

If you are <u>currently</u> on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are **<u>pending</u>**. Submit a copy of the police report/criminal complaint for each of the following pending charges.

PENDING CHARGE	DATE OF ARREST	LOCATION OF ARREST (city/state)

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

_____

_____

_____

_____

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

_____
Signature

State of _____ County of _____

Signed and sworn before me this _____ day of _____, 20 _____ by _____
(applicant's name)

_____
Signature of Notary Public

My commission (is permanent) _____ expires _____. **SEAL**

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NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.[a] An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at *http://www.legis.state.wi.us/rsb/code/rl/rl.html* and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at *http://www.drl.state.wi.us/* under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 2/03) ss. 15.04 (1) (m), 19.35, Stats.

[a] Section RL 4.06 of the Wisconsin Administrative Code